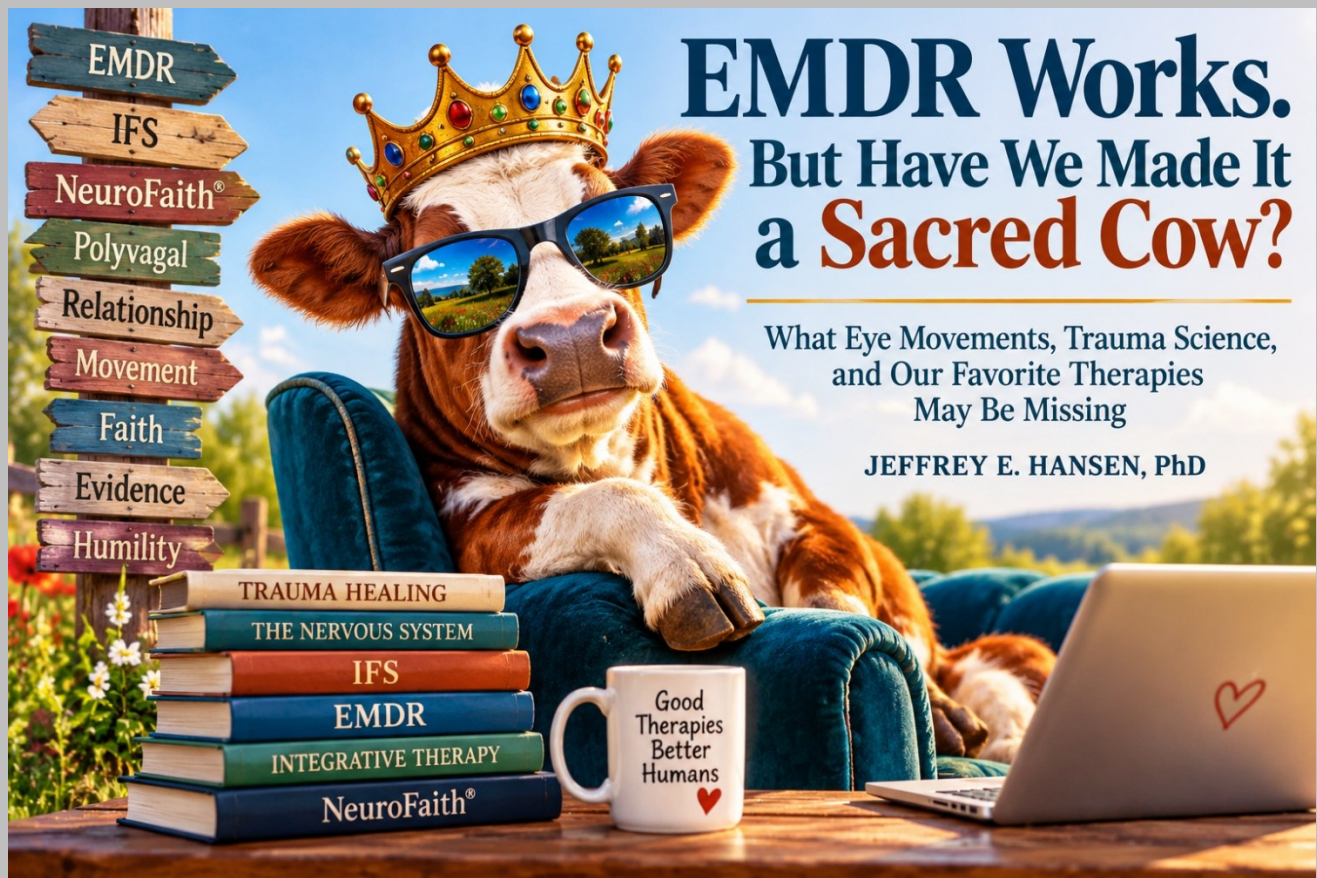




EMDR Works. But Have We Made It a Sacred Cow?

What Eye Movements, Trauma Science,
and Our Favorite Therapies
May Be Missing

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Something About EMDR Never Quite Settled for Me

I have no idea why I started thinking about EMDR this morning. My mind does that. It wanders hither and yon, lands on something seemingly out of nowhere, and then sometimes refuses to leave it alone. People have told me that I am a deep thinker. Maybe I am. Maybe I am a strange thinker. Maybe I just think too much. Whatever the explanation, this morning my mind landed on Eye Movement Desensitization and Reprocessing, better known as EMDR, and I found myself returning to a question that has bothered me for years.

I trained in EMDR perhaps five years ago. I liked it. I found it interesting, and more importantly, I saw some good clinical outcomes. People got better. Memories that had carried tremendous emotional weight sometimes became less distressing. Patients could approach experiences they had previously avoided, and I could see changes occurring right there in the room. Something was happening.

So let me be clear from the beginning. This is not an argument that EMDR does not work. I have used it. I respect it. I have seen it help people, and I still refer patients for EMDR when I believe it may be useful.

But there was always something about the explanation that did not completely settle for me.

Being something of a neuroscience nerd, I have difficulty simply accepting that a treatment works without wanting to crawl underneath the hood and understand why. I want the conceptual model to make sense. I want our explanation to fit what we actually know about memory, attention, the brain, the autonomic nervous system, relationship, and human behavior. And when we do not know, I think we should have enough humility to say that too.

That curiosity eventually contributed to my development of NeuroFaith®, an integrative approach to trauma treatment bringing together polyvagal-informed therapy, neurocardiology and physiological self-regulation, Internal Family Systems, and Christian spirituality when faith is appropriate and meaningful to the person. Movement and behavioral activation also play an important role. NeuroFaith® grew from my increasing conviction that trauma does not live in one place. It becomes embedded across interacting systems: brain, body, autonomic nervous system, relationships, protective adaptations, identity, meaning, and sometimes faith.

And that brings me back to EMDR.

My question is not whether it works.

My question is whether it works for the reasons we think it does.

Francine Shapiro and a Walk in the Park

The history of EMDR is fascinating because it did not begin with an elaborate neuroscience theory. It began with an observation.

Francine Shapiro's academic path was itself unusual. Before entering psychology, much of her scholarly life had been in English literature. She published literary criticism and edited a volume of Thomas Hardy's poetry before ultimately moving into psychology and becoming a clinical psychologist. That history does not diminish what she accomplished. If anything, I find it fascinating. Sometimes important discoveries come from people willing to notice something everyone else has walked past.

In 1987, Shapiro was walking through a park when she noticed that spontaneous movements of her eyes appeared to diminish the distress associated with disturbing thoughts. She became curious. She began experimenting and subsequently tested whether deliberate eye movements could reduce the emotional intensity associated with troubling memories in other people. Her early procedure became Eye Movement Desensitization, or EMD. Importantly, Shapiro herself came to recognize that eye movements alone did not constitute a comprehensive treatment and added cognitive and other therapeutic components. In 1991, the approach became Eye Movement Desensitization and Reprocessing, or EMDR, reflecting the broader information-processing theory she was developing to explain the clinical changes she observed (Shapiro, 1989).

That sequence matters. Shapiro did not begin with an established neurobiological model of traumatic memory from which she predicted that moving the eyes from side to side would treat PTSD. She noticed something first. The phenomenon came first. The theoretical explanations came afterward.

There is nothing inherently wrong with that. Science often proceeds exactly this way. Something unexpected happens. Someone curious enough notices it. We determine whether the phenomenon can be reproduced, and then we try to understand why it happened.

But the observation and the explanation for the observation are not the same thing.

Perhaps Francine Shapiro discovered something much bigger than eye movements.

And perhaps she did not even know it.

If It Is About REM, Why Do We Not Need the Eyes?

Early explanations for EMDR included an intriguing comparison with rapid eye movement, or REM, sleep. Shapiro proposed that the rhythmic eye movements might function somewhat like processes occurring during dreaming, and later researchers developed considerably more sophisticated versions of the REM hypothesis. The general idea was compelling: perhaps the eye movements helped place the brain into a state favorable to processing emotionally charged memories and integrating them into broader memory networks.

It is a fascinating hypothesis.

But a hypothesis is not a mechanism simply because it sounds neuroscientific.

This becomes particularly important because EMDR does not necessarily require eye movements. Clinicians may use alternating auditory tones. They may use tapping or tactile stimulation. Patients may hold pulsers, sometimes called buzzers, that alternate stimulation between their hands. A vibration alternating between the hands is not a rapid eye movement. A sound alternating between the ears is not REM sleep.

To be fair, this does not establish that every form of bilateral stimulation is equivalent. They may not be. Eye movements may have particular properties that make them especially effective. But if nonvisual procedures can also contribute to therapeutic change, then an explanation requiring the eyes themselves to be the central neurological engine begins to look increasingly incomplete.

A major systematic review by Landin-Romero and colleagues (2018) examined 87 studies addressing proposed mechanisms of EMDR. The investigators grouped the explanations into psychological, psychophysiological, and neurobiological models. They found reasonable empirical support for the working-memory hypothesis and for physiological changes occurring during successful EMDR. But their conclusion was remarkably important: despite decades of research, investigation into EMDR's mechanisms remained insufficient to establish firm conclusions. They described the mechanistic science as still being in its infancy.

That should give us some humility.

The working-memory explanation makes considerable sense. When a person deliberately retrieves an emotionally charged memory while simultaneously performing another sufficiently demanding task, both activities compete for limited working-memory resources. The memory may consequently become less vivid and less emotionally intense. That explanation has accumulated meaningful experimental support.

But even that does not appear to explain everything.

Maybe we need to get some altitude.

Instead of staring exclusively at the moving finger, perhaps we should look at the entire therapeutic event. A person deliberately activates a painful memory while simultaneously attending to something occurring in the present. Attention is divided. Working memory is occupied. The traumatic memory is activated under circumstances radically different from those in which it was originally encoded. The person is here rather than there. The event is being remembered, but it is not happening again.

And there is something else that I think we sometimes underestimate.

There is another human being in the room.

The Blind Men and the Elephant

Perhaps the most revealing metaphor in the Landin-Romero review comes near its conclusion, where the authors invoke the old parable of the Blind Men and the Elephant. In the story, six blind men encounter an elephant and, having never known one before, attempt to understand what kind of creature stands before them. The problem is that each man touches only one part of the animal. One feels the elephant's broad side and declares that an elephant must be like a wall. Another encounters the tusk and insists that an elephant is like a spear. Another takes hold of the trunk and concludes that it must be something like a snake. The remaining men encounter the leg, the ear, and the tail and confidently describe the elephant as resembling a tree, a fan, and a rope. When they compare their conclusions, they discover that they are in complete disagreement.

What makes the parable so wonderful is that none of the men is entirely wrong. Each has encountered something real. The side really does feel something like a wall. The tusk is spear-like. The trunk can feel like a snake, the leg like a tree, the ear like a fan, and the tail like a rope. Their error occurs when each man assumes that the small portion he has encountered explains the entire animal.

Landin-Romero and colleagues (2018) suggest that our attempts to explain EMDR may look remarkably similar. After reviewing 87 studies examining proposed mechanisms of action, they found evidence pointing in several different directions. One line of research emphasizes working-memory taxation. Another focuses on the orienting response or psychophysiological de-arousal. Others examine bilateral stimulation, REM-like processes, attentional changes, memory processing, or alterations in neural activity. These explanations do not necessarily have to cancel one another out. Several of them may be identifying something real. The problem comes when we touch one part of a complex therapeutic process and conclude that we have discovered the whole elephant.

That seems especially relevant when we return to the question of eye movements. If the essential mechanism were simply that eye movements reproduce something analogous to REM sleep, then auditory tones and alternating tactile stimulation become difficult to explain. Landin-Romero and colleagues themselves identify this as a limitation of the REM-like physiological account. Yet if we broaden our view and consider that EMDR may simultaneously affect attention, working memory, arousal, memory processing, and other neurobiological systems, the apparent contradiction becomes considerably less mysterious.

This is why I find the elephant metaphor so compelling. Perhaps the problem is not that every theory of EMDR has been wrong. Perhaps several theories have been partly right. We have simply been standing in different places, touching different parts of the same complicated process and then arguing with one another about whose description is correct.

The authors ultimately move toward something very close to that conclusion. EMDR is a complex therapeutic intervention, and multiple mechanisms may be operating simultaneously. They suggest that a more integrative model may ultimately be necessary to understand how it works (Landin-Romero et al., 2018). To me, that is not a weakness in the science. It is an invitation to widen the lens.

And it takes me back to Francine Shapiro walking through that park in 1987. Perhaps what she discovered was considerably larger than the eye movements that first caught her attention. Perhaps she stumbled onto a way of creating conditions in which a painful memory could be activated while attention, arousal, cognition, physiology, and memory itself were being asked to do something different.

Maybe Francine Shapiro discovered an elephant.

And for a long time, we have been arguing about the trunk.

Another Nervous System in the Room

There is another part of this elephant that I think deserves considerably more attention: the traumatized person is not sitting there alone. There is another human being in the room.

Think about what actually occurs during good trauma therapy. We ask someone to approach something that his nervous system may have spent years telling him to avoid. He deliberately brings the memory forward and begins noticing what happens as images, physical sensations, fear, grief, guilt, anger, or shame emerge. Rather than escaping the experience, he remains with it long enough for something different to occur. The traumatic experience is being activated, but it is being activated under circumstances radically different from those in which it was originally encoded. The person is here rather than there. The terrible event is being remembered, but it is not happening again.

And importantly, another person is sitting nearby. There is attention, structure, expectation, relationship, and, when therapy is going well, an experience of safety. The therapist remains present while the patient approaches what was once unbearable. From a nervous-system perspective, I think that matters enormously. One human nervous system is approaching something associated with danger while another regulated nervous system remains close, attentive, predictable, and available.

How much of what happens during EMDR belongs specifically to bilateral stimulation? How much involves working-memory taxation, exposure, attentional flexibility, autonomic regulation, or memory updating and reconsolidation? How much is influenced by expectation and therapeutic relationship? And how much emerges because several of these things are occurring simultaneously while the patient remains in relationship with another human being?

I do not know.

And perhaps that is exactly the point.

What Do We Tell the Patient?

This is where the question becomes more than academic for me. It becomes an issue of informed consent.

If we do not actually know the neurobiological mechanism responsible for a treatment's effectiveness, then I think we have an ethical responsibility to say so. We should not give patients neurological gobbledegook because it sounds impressive. We should not take a plausible theoretical explanation and present it as established neuroscience simply because it makes the treatment easier to explain or makes us sound more certain.

If REM-like processing is a hypothesis, call it a hypothesis. If working-memory taxation has stronger empirical support, say that. If memory reconsolidation may be involved but has not been demonstrated to explain the entire treatment effect, say that too.

There is nothing embarrassing about telling a patient, “We have good evidence that this treatment helps many people with PTSD. We have several theories about why it works, but we do not yet completely understand the neurological mechanism.”

That is not weakness.

That is honest informed consent.

EMDR Works. The Harder Question Is How Well, Compared With What, and for How Long?

If I am going to challenge some of the theoretical claims surrounding EMDR, I also need to acknowledge clearly that the treatment has substantial empirical support.

Yang and colleagues (2026) recently published a large meta-analysis examining 65 randomized controlled trials involving 3,342 adults with PTSD. The immediate effect on PTSD symptoms was substantial, with a pooled Hedges' g of 0.96. Thirty-two studies contributed follow-up data, and the pooled effect remained significant at follow-up, $g = 0.80$. At first glance, that sounds pretty darn impressive. The investigators concluded that EMDR demonstrated immediate effects and “sustained effects at follow-up” (Yang et al., 2026).

Before we get too excited about the word sustained, however, we need to look under the hood.

The immediate-treatment studies were already highly heterogeneous, $I^2 = 85.76\%$. At follow-up, heterogeneity climbed to $I^2 = 89.72\%$. Heterogeneity is one of those statistical terms that can make people's eyes glaze over, but here it matters enormously. In plain English, the studies were producing substantially different estimates of how well EMDR worked, beyond the variation we would expect simply from sampling error. These studies were not all giving us the same picture.

Why might that be? The trials differed in trauma populations, comparison conditions, intervention characteristics, methodologies, and other important variables. And importantly for the question of durability, they used variable follow-up periods.

So what exactly does follow-up mean?

That is not a trivial question. Thirty-two studies contributing some form of follow-up data is not the same thing as 32 studies evaluating everybody at one standardized long-term endpoint. These were not all trials bringing patients back at one year, two years, or five years and asking the same questions. Yet these differing observations contribute to a pooled “follow-up” effect.

That makes the word sustained considerably less satisfying to me.

The authors themselves acknowledge important weaknesses in the evidence base. Most studies were not judged to be at low overall risk of bias. Concerns included deviations from intended interventions, missing outcome data, and limitations involving randomization and allocation concealment. The investigators

appropriately caution that confidence in the pooled estimates should therefore be tempered (Yang et al., 2026).

There is another finding worth noticing. The size of EMDR's apparent advantage changed substantially depending upon what it was compared against. Its advantage was much larger against waiting-list or treatment-as-usual conditions and considerably smaller when compared with CBT or other active treatments. That does not mean EMDR is ineffective. It means that showing an active psychotherapy works better than asking a suffering person to wait for treatment is a very different scientific test from demonstrating superiority over another legitimate trauma treatment.

None of this makes the Yang et al. study meaningless. It tells us something important: EMDR reduces PTSD symptoms, and improvement can remain detectable beyond treatment.

But it does not answer the question I care about nearly as well:

How durable is that improvement over clinically meaningful periods of time?

Six Weeks Is Six Weeks

This problem is hardly unique to psychotherapy. It reminds me of a longstanding methodological criticism of the psychotropic medication literature, a literature about which I have had concerns for years. A relatively short acute trial may demonstrate statistically significant improvement, and that tells us something useful about what happened during that period. But six or eight weeks of improvement tells me remarkably little about what happens to a human being over the next two years.

Six weeks is six weeks.

It is not a year.

And it sure as heck is not recovery.

PTSD, depression, and anxiety are not six-week problems. Trauma certainly is not. If we are going to use words such as sustained, durable, or long-term, then I think our research needs to earn those words.

Show me six months. Show me one year. Show me two years. Better yet, show me five. Tell me how many patients required additional psychotherapy during that period. Tell me how many returned for additional EMDR. Tell me how many received another trauma treatment. Tell me how many continued to meet diagnostic criteria for PTSD. Tell me what happened to their marriages, relationships, occupational functioning, substance use, physical health, and quality of life.

Tell me whether they merely scored lower on a symptom inventory or whether their lives actually got better.

Those studies are difficult. They are expensive. People drop out. Participants obtain other treatments. Life gets messy.

But trauma is messy.

We cannot demand that the human being become simpler merely because simpler research is easier to conduct.

And Another Meta-Analysis Gives Us Reason to Be Careful

A second recent review makes this uncertainty particularly difficult to ignore. Villegas-Ortega and colleagues (2025) took a narrower approach and examined 12 randomized controlled trials involving 690 participants comparing EMDR with waiting-list controls. Again, the numerical results favored EMDR. PTSD symptoms were substantially lower immediately following treatment, $SMD = -1.19$, 95% CI $[-1.70, -0.68]$. At the available follow-up assessments, EMDR continued to show an advantage, $SMD = -0.88$, 95% CI $[-1.62, -0.13]$.

Diagnostic remission initially looks impressive as well. Participants receiving EMDR were more likely to lose the PTSD diagnosis following treatment, $RR = 2.13$, 95% CI $[1.08, 4.23]$. At follow-up, the estimated relative risk was 3.56.

But look at the confidence interval around that follow-up estimate: 0.82 to 15.48.

That is an enormous range, and because it crosses 1.0, the follow-up estimate does not establish a statistically reliable difference in diagnostic remission. In plain language, the estimate is extremely imprecise.

After formally grading the evidence, the investigators rated its certainty as low to very low. Why? Not because the studies found no benefit. They did. The problem was how confident we could reasonably be in those estimates. The review identified risk of bias, particularly involving masking and allocation concealment. Follow-up evidence was imprecise. Long-term effects remained unclear. And none of the included trials assessed several outcomes I would very much like to know about before using the word recovery: quality of life, treatment acceptability, or adverse effects (Villegas-Ortega et al., 2025).

That is not an argument that EMDR does not work.

It is an argument that we need better research.

Put these two recent analyses beside one another and I think the scientifically responsible conclusion becomes fairly clear. EMDR has meaningful evidence for reducing PTSD symptoms. There is evidence that improvement can persist beyond the end of treatment. But the literature gives us considerably less confidence about genuinely long-term durability, and the evidence certainly does not establish that completing a relatively brief EMDR protocol constitutes comprehensive or permanent recovery from trauma.

Those are different claims.

We should stop pretending they are the same.

When Treatment Becomes Ideology

This brings me to a caution I would offer my EMDR colleagues, but also to myself and to every clinician who has ever fallen in love with a particular therapeutic model:

Do not become a cult leader.

I use that language intentionally and perhaps a little provocatively. I am not suggesting that EMDR is a cult or that clinicians practicing it are cult members. I am talking about a professional posture that can develop around almost anything when enthusiasm gradually hardens into allegiance.

Anything can become a cult if we hold onto it tightly enough.

Cults do not particularly like uncomfortable questions. They protect the central narrative. Contradictory information becomes threatening. Limitations get explained away. Preserving the ideology gradually becomes more important than discovering whether the ideology is true.

Science is supposed to do exactly the opposite. Science should welcome the irritating question. It should invite somebody to poke holes in our favorite theory. Good science should permit us to say, "We thought this was how it worked. The evidence is telling us something different. We need to change our minds."

That applies to EMDR. It applies to CBT. It applies to psychopharmacology. It applies to polyvagal theory. It applies to Internal Family Systems.

And it absolutely applies to NeuroFaith®.

The day I begin telling people that NeuroFaith® is the treatment for trauma, somebody needs to pull me aside and remind me of what I wrote here. It is not the treatment. It is an integrative framework that attempts to bring several potentially transformational approaches into conversation with one another. It does not own the truth.

The patient does not exist to prove that our model is right.

The model exists to help the patient.

When the Protocol Ends

This is where my own clinical experience has made me cautious about confusing successful completion of a protocol with recovery from trauma. I have worked with people who previously completed substantial courses of EMDR and benefited from them. Some could discuss memories that once overwhelmed them. Their distress had diminished. The treatment had done something important.

And yet they were sitting in my office.

Not necessarily because EMDR had failed.

Because their healing was unfinished.

They still did not understand why their bodies suddenly shifted into alarm. They did not understand why apparently minor events triggered reactions wildly disproportionate to what was occurring in the present. They did not understand why connection sometimes felt dangerous, why anger appeared before vulnerability, why they shut down, or why their nervous systems continued detecting threat long after the original danger had passed.

The memory may have become quieter.

But the person still needed to understand the nervous system carrying that memory.

Underneath the physiology were often deeper psychological wounds. Shame had become incorporated into identity. Guilt had become fused with responsibility. Relationships had reorganized themselves around mistrust. Protective strategies that once made perfect sense had become rigid ways of living. The person's internal story had gradually become something like: I am damaged. I am unsafe. I cannot trust. I failed. I should have done more. I am no longer who I once was.

This is one reason I find Internal Family Systems, or IFS, useful within a larger trauma framework. IFS gives us a way of understanding apparently problematic reactions not merely as symptoms to eliminate, but often as protective parts of the person that developed for understandable reasons. The angry part, hypervigilant part, detached part, perfectionistic part, controlling part, or part that refuses ever again to become vulnerable may be doing exactly what it learned was necessary to keep the person safe.

Instead of declaring war on those parts, we become curious about them. What happened to you? What are you protecting? What are you afraid would happen if you stopped doing your job?

That begins moving us beyond reducing the emotional charge of a memory and toward understanding how trauma reorganized the person.

The Seduction of the Protocol

I think psychology has become increasingly enamored with protocols. There are understandable reasons. Protocols can be standardized, manualized, taught, researched, measured, reimbursed, and reproduced. Health systems like them. Researchers like them. Insurance companies certainly like them.

There is tremendous value in that.

But there is also danger.

At some point the therapist can begin looking less like a healer and more like a technician.

I sometimes think about taking my Toyota Land Cruiser into the dealership. There is a procedure for almost everything. A particular repair is allocated a particular number of labor hours. There are diagnostic codes, service intervals, technical procedures, torque specifications, and prescribed sequences for getting from problem to repair.

That makes perfect sense when you are working on a machine.

Human beings are not Land Cruisers.

Trauma does not arrive in standardized units, and it does not conveniently organize itself into five sessions, eight sessions, ten sessions, or twelve. The person sitting across from us brings a nervous system, developmental history, temperament, attachments, losses, relationships, beliefs, protective adaptations, identity, body, morality, and perhaps faith. The traumatic experience becomes woven into all of it.

Protocols are useful.

But protocols are maps. They are not the territory.

The Memory May Change. Has the Story Changed?

This is where the neuroscience of the default mode network becomes especially interesting to me. The default mode network, or DMN, is deeply involved in self-referential thought, autobiographical memory, internally directed attention, imagining the future, and aspects of our continuing construction of self. When the demands of the external world recede, the brain does not simply shut off. It turns inward. It remembers. It anticipates. It interprets.

And it tells stories.

Trauma can become woven deeply into those stories. The event may have occurred ten, twenty, or forty years ago, yet its implications continue to be rehearsed: This is who I am. This is what people are like. This is what happens when I trust. This is what I deserve. This is what my future will be. God abandoned me.

At that point we are dealing with more than a disturbing memory.

We are dealing with an architecture of identity.

EMDR explicitly addresses negative and positive cognitions, and we should give it full credit for doing so. My question is not whether cognition appears in the protocol. It does. My question is whether changing the emotional intensity and cognitive association attached to particular traumatic memories necessarily penetrates deeply enough to alter an autobiographical narrative that may have been rehearsed thousands upon thousands of times.

A person can know that the traumatic event is over. His physiological response can diminish. He can remember what happened without becoming overwhelmed.

The memory has changed.

But has the story changed?

From Desensitization Toward Restoration

This is where NeuroFaith® fits for me. It is not a replacement for EMDR, and I do not want it to become another rigid protocol claiming ownership over trauma healing. I think of it as a larger framework for understanding the human being in whom the trauma resides.

Polyvagal-informed work helps the person understand what the autonomic nervous system learned about danger and safety and why protective states continue to emerge even when the original danger is gone. Neurocardiology and physiological regulation give the person practical ways of recognizing and influencing state rather than simply being hijacked by it. IFS provides a language for approaching wounded and protective parts with curiosity rather than shame. Movement reminds us that healing occurs through the body as well as through thought. Relationship provides repeated experiences of safety with another human being.

And when Christian faith is meaningful to the person, spirituality allows us to approach questions that neither a PTSD checklist nor a brain scan can answer: Who am I now? What does my suffering mean? What do I do with guilt? Where was God? Can there be redemption in a story I never would have chosen?

Understanding matters to me.

There is something profoundly different about a person moving from Something is wrong with me to My nervous system learned to protect me this way, and now I can teach it something different. There is something different about discovering that the angry or detached part is not evidence of being defective but may represent an adaptation that once helped the person survive. And there is something different again when the person begins consciously rewriting the autobiographical story that trauma has been rehearsing in the background for years.

EMDR can fit beautifully within that larger landscape. I will continue referring people for it when I believe it may help them. Cognitive therapies have a place. Exposure-based treatments have a place. IFS has a place. Medication sometimes has a place. Autonomic and body-based approaches have a place. Faith can have a place when it belongs to the person.

None of these approaches needs to become the whole answer.

Perhaps that is ultimately what Francine Shapiro's discovery invites us to consider. She may have discovered something much bigger than eye movements without realizing just how big it was. Perhaps what she stumbled upon was not merely a clever technique for moving the eyes, but one particularly powerful way of creating conditions in which a human being can approach what was unbearable, remain anchored in the present, experience the memory differently, and begin to change.

That is worth celebrating.

It is also worth continuing to question.

Our job is not to protect EMDR. It is not to protect NeuroFaith®. It is not to protect CBT, IFS, polyvagal theory, psychopharmacology, or whatever therapeutic school happens to be printed on our latest certificate.

Our job is to tell the truth as best we know it, to be honest about what we do not know, to remain curious enough to change our minds, and to use whatever good tools we have to help the human being sitting across from us.

Because ultimately the question is larger than whether EMDR works.

What does this particular human being need in order to heal?

And perhaps that is where all good trauma treatment should begin.

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